FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032854

Facility Name: HIGHLAND PARK HEALTH CARE, INC.

Address: 50 PLEASANT AVENUE (Number) HIGHLAND PARK (City) 60040 (Zip Code)

County: LAKE

Telephone Number: (847) 432-9142 **Fax #** (847) 432-4740

IDPA ID Number: 36-3539847

Date of Initial License for Current Owners: 10/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) CARY BUXBAUM

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	82	Skilled (SNF)	82	30,012	1
2		Skilled Pediatric (SNF/PED)			2
3	13	Intermediate (ICF)	13	4,758	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	95	TOTALS	95	34,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,216	1,050	553	5,819	8
9	SNF/PED					9
10	ICF	19,205	5,945		25,150	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,421	6,995	553	30,969	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.07%

D. How many bed-hold days during this year were paid by Public Aid? 157 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 4 and days of care provided 553

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	146,554	13,354	7,800	167,708		167,708	75	167,783			1
2	Food Purchase		129,980		129,980	(19,435)	110,545	(292)	110,253			2
3	Housekeeping	76,567	10,689		87,256		87,256	361	87,617			3
4	Laundry	27,695	12,967		40,662		40,662		40,662			4
5	Heat and Other Utilities			75,661	75,661		75,661	1,139	76,800			5
6	Maintenance	25,618	4,784	72,679	103,081		103,081	(13,870)	89,211			6
7	Other (specify):*							3,318	3,318			7
8	**TOTAL General Services**	276,434	171,774	156,140	604,348	(19,435)	584,913	(9,269)	575,644			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	890,239	44,121	182,839	1,117,199		1,117,199	7,439	1,124,638			10
10a	Therapy			7,230	7,230		7,230		7,230			10a
11	Activities	45,742	2,102	3,124	50,968		50,968		50,968			11
12	Social Services	23,901		1,375	25,276		25,276		25,276			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							1,472	1,472			15
16	**TOTAL Health Care and Programs**	959,882	46,223	196,968	1,203,073		1,203,073	8,911	1,211,984			16
	C. General Administration											
17	Administrative	61,509		127,171	188,680		188,680	(71,186)	117,494			17
18	Directors Fees											18
19	Professional Services			90,977	90,977		90,977	(44,440)	46,537			19
20	Dues, Fees, Subscriptions & Promotions			28,274	28,274		28,274	(14,152)	14,122			20
21	Clerical & General Office Expenses	61,427	15,329	52,589	129,345		129,345	1,981	131,326			21
22	Employee Benefits & Payroll Taxes			188,393	188,393	19,435	207,828		207,828			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,362	3,362		3,362	378	3,740			24
25	Other Admin. Staff Transportation							1,580	1,580			25
26	Insurance-Prop.Liab.Malpractice			39,794	39,794		39,794	531	40,325			26
27	Other (specify):*							12,357	12,357			27
28	**TOTAL General Administration**	122,936	15,329	530,560	668,825	19,435	688,260	(112,951)	575,309			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,359,252	233,326	883,668	2,476,246		2,476,246	(113,309)	2,362,937			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

HIGHLAND PARK HEALTH CARE, INC.
0032854
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	19,435	
2	FOOD		19,435

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. #0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			47,363	47,363		47,363	82,996	130,359			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,037	15,037		15,037	203,813	218,850			32
33	Real Estate Taxes			48,097	48,097		48,097	2,302	50,399			33
34	Rent-Facility & Grounds			258,720	258,720		258,720	(258,720)				34
35	Rent-Equipment & Vehicles			7,647	7,647		7,647	4,840	12,487			35
36	Other (specify):*							4,008	4,008			36
37	**TOTAL Ownership**			376,864	376,864		376,864	39,239	416,103			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		7,262	19,760	27,022		27,022	(635)	26,387			39
40	Barber and Beauty Shops			758	758		758		758			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,156	52,156		52,156		52,156			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		7,262	72,674	79,936		79,936	(635)	79,301			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,359,252	240,588	1,333,206	2,933,046		2,933,046	(74,705)	2,858,341			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,914	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(292)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(38,680)	21		24
25	Fund Raising, Advertising and Promotional	(3,765)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	869	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(10,736)	20		28
29	Other-Attach Schedule	(15,342)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (56,032)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(18,673)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (18,673)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (74,705)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

HIGHLAND PARK HEALTH CARE, INC.

ID# 0032854

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Trust Fees	(250)	20	2
3	IL Council COPE Dues	(124)	20	3
4	Capitalized R&M	(12,672)	6	4
5	Prior Period Mgmt Fee	(2,296)	17	5
6				6
7				7
8				8
9				9
10				10
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82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(15,342)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(1,080)			1,155				75	1
2	Food Purchase	(292)											(292)	2
3	Housekeeping			361									361	3
4	Laundry													4
5	Heat and Other Utilities			488	651								1,139	5
6	Maintenance	(12,672)		301	3,066	(4,565)							(13,870)	6
7	Other (specify):*				349	2,969							3,318	7
8	**TOTAL General Services**	(12,964)		1,150	4,066	(2,676)			1,155				(9,269)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				8,696				(1,257)				7,439	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				1,472								1,472	15
16	**TOTAL Health Care and Programs**				10,168				(1,257)				8,911	16
	C. General Administration													
17	Administrative	(2,296)		8,435	3,468	(80,499)		(294)					(71,186)	17
18	Directors Fees													18
19	Professional Services			(50,998)	1,067	5,473		18					(44,440)	19
20	Fees, Subscriptions & Promotions	(14,875)		217	494			12					(14,152)	20
21	Clerical & General Office Expenses	(37,811)		28,007	11,759			26					1,981	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			110	268								378	24
25	Other Admin. Staff Transportation			384	1,196								1,580	25
26	Insurance-Prop.Liab.Malpractice			246	263			22					531	26
27	Other (specify):*			4,400	2,205	5,518		234					12,357	27
28	**TOTAL General Administration**	(54,982)		(9,199)	20,720	(69,508)		18					(112,951)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(67,946)		(8,049)	34,954	(72,184)		18	(102)				(113,309)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	11,914	66,825	1,798	2,459								82,996	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		201,639	701	1,456			17					203,813	32
33	Real Estate Taxes			908	1,394								2,302	33
34	Rent-Facility & Grounds		(258,720)										(258,720)	34
35	Rent-Equipment & Vehicles			1,551	2,977			312					4,840	35
36	Other (specify):*		4,008										4,008	36
37	**TOTAL Ownership**	11,914	13,752	4,958	8,286			329					39,239	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(635)				(635)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**								(635)				(635)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(56,032)	13,752	(3,091)	43,240	(72,184)		347	(737)				(74,705)	45

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule Attached		See Schedule Attached		See Schedule Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 258,720	Highland Park Health Care Assoc LLC	100.00%	$	$ (258,720)	1
2	V	32	Interest Expense		Highland Park Health Care Assoc LLC	100.00%	201,639	201,639	2
3	V	30	Depreciation		Highland Park Health Care Assoc LLC	100.00%	66,825	66,825	3
4	V	36	Amortization		Highland Park Health Care Assoc LLC	100.00%	4,008	4,008	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 258,720			$ 272,472	$ * 13,752	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 361	$ 361	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	488	488	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	301	301	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	8,435	8,435	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,122	1,122	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	217	217	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	28,007	28,007	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	110	110	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	384	384	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	246	246	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	4,400	4,400	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,798	1,798	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	701	701	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	908	908	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	1,551	1,551	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	52,120	PREFERRED BOOKKEEPING	100.00%		(52,120)	32
33	V	19	COMPUTER	2,280	PREFERRED BOOKKEEPING	100.00%	2,280		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 54,400			$ 51,309	$ * (3,091)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 651	$ 651	15
16	V	6	REPAIRS AND MAINT.	0	S.I.R. MANAGEMENT, INC.	100.00%	3,066	3,066	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	349	349	17
18	V	10	NURSING	0	S.I.R. MANAGEMENT, INC.	100.00%	8,696	8,696	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	1,472	1,472	19
20	V	17	ADMINISTRATIVE	0	S.I.R. MANAGEMENT, INC.	100.00%	3,468	3,468	20
21	V	19	PROFESSIONAL FEES	0	S.I.R. MANAGEMENT, INC.	100.00%	1,067	1,067	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	494	494	22
23	V	21	CLERICAL & GENERAL	0	S.I.R. MANAGEMENT, INC.	100.00%	11,759	11,759	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	268	268	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	1,196	1,196	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	263	263	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,205	2,205	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,459	2,459	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	1,456	1,456	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	1,394	1,394	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	2,977	2,977	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 43,240	$ * 43,240	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 0	S.I.R. MANAGEMENT, INC.	100.00%	$ 2,511	$ 2,511	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	422	422	16
17	V	17	ADMIN./LEGAL SALARIES	120,555	S.I.R. MANAGEMENT, INC.	100.00%	40,056	(80,499)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	5,473	5,473	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	5,518	5,518	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB	0	S.I.R. MANAGEMENT, INC.	100.00%	0		22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	0		23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	15,016	S.I.R. MANAGEMENT, INC.	100.00%	10,451	(4,565)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,819	1,819	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	7,800	S.I.R. MANAGEMENT, INC.	100.00%	4,209	(3,591)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	728	728	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 143,371			$ 71,187	$ * (72,184)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 44,840	$ 44,840	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	44,840	CCS EMPLOYEE BENEFIT GROUP	100.00%		(44,840)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 44,840			$ 44,840	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 18	$ 18	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	12	12	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	26	26	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	22	22	18
19	V	32	INTEREST		ECM OWNERS COUNCIL	100.00%	17	17	19
20	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	312	312	20
21	V	17	MANAGEMENT FEES	4,320	ECM OWNERS COUNCIL	100.00%		(4,320)	21
22	V								22
23	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	4,026	4,026	23
24	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	234	234	24
25	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%	0		25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,320			$ 4,667	$ * 347	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	ENTERAL EQUIPMENT	$ 758	PARAMOUNT HEALTH CARE SYSTEMS	100.00%	$ 123	$ (635)	15
16	V	10	ENTERAL EQUIPMENT	1,344	PARAMOUNT HEALTH CARE SYSTEMS	100.00%	87	(1,257)	16
17	V	1	NUTRITIONAL SUPPLEMENTS		PARAMOUNT HEALTH CARE SYSTEMS	100.00%	1,155	1,155	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,102			$ 1,365	$ * (737)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Stockholder	Administrative	40.00%	See Attached	2.17	4.30	Alloc-SIR	$ 12,660	17-7	1
2	Arturo Rominiquit	Relative	Clerical	0.00	See Attached	2.37	5.93	Alloc-Prf	1,297	21-7	2
3	Eric Rothner	Stockholder	Administrative	60.00%	See Attached	0.3	0.42	Alloc-SIR	3,224	17-7	3
4	Nettie Guzman	Relative	Dietary	0.00	See Attached	2.65	4.82	Alloc-SIR	2,511	1-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 19,692		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	878,492	11	$ 6,088	$	52,120	$ 361	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	878,492	11	8,220		52,120	488	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	878,492	11	5,069		52,120	301	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	878,492	11	142,165	142,165	52,120	8,435	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	878,492	11	18,910		52,120	1,122	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	878,492	11	3,657		52,120	217	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	878,492	11	472,061	403,426	52,120	28,007	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	878,492	11	1,858		52,120	110	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	878,492	11	6,465		52,120	384	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	878,492	11	4,146		52,120	246	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	878,492	11	74,163		52,120	4,400	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	878,492	11	30,298		52,120	1,798	12
13	32	INTEREST	BOOK./ACCNT.INCOME	878,492	11	11,823		52,120	701	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	878,492	11	15,297		52,120	908	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	878,492	11	26,147		52,120	1,551	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						2,280	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 826,367	$ 545,591		$ 51,309	25

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	642,911	10	$ 13,508	$	30,969	$ 651	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	642,911	10	63,644	42,834	30,969	3,066	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	642,911	10	7,250		30,969	349	3
4	10	NURSING	PATIENT DAYS	642,911	10	180,529	180,529	30,969	8,696	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	642,911	10	30,553		30,969	1,472	5
6	17	ADMINISTRATIVE	PATIENT DAYS	642,911	10	71,994	71,994	30,969	3,468	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	642,911	10	22,153		30,969	1,067	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	642,911	10	10,256		30,969	494	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	642,911	10	244,124	177,193	30,969	11,759	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	642,911	10	5,556		30,969	268	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	642,911	10	24,821		30,969	1,196	11
12	26	INSURANCE	PATIENT DAYS	642,911	10	5,468		30,969	263	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	642,911	10	45,778		30,969	2,205	13
14	30	DEPRECIATION	PATIENT DAYS	642,911	10	51,045		30,969	2,459	14
15	32	INTEREST	PATIENT DAYS	642,911	10	30,234		30,969	1,456	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	642,911	10	28,948		30,969	1,394	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	642,911	10	61,803		30,969	2,977	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 897,664	$ 472,550		$ 43,240	25

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	642,911	10	$ 52,122	$ 52,122	30,969	$ 2,511	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	642,911	10	8,770		30,969	422	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	642,911	10	831,558	831,558	30,969	40,056	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	642,911	10	113,620		30,969	5,473	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	642,911	10	$ 114,558	$	30,969	$ 5,518	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	56,277	56,277			8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	$ 9,470	$		$	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	237,604	10	165,366	165,366	15,016	10,451	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	237,604	10	$ 28,790	$	15,016	$ 1,819	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	67,672	67,672	7,800	4,209	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	11,698		7,800	728	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,459,901	$ 1,172,995		$ 71,187	25

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 44,840	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 44,840	25

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 676-2026
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	$ 400	$	4,320	$ 18	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		4,320	12	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	579		4,320	26	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	496		4,320	22	4
5	32	INTEREST	ECMOC MGMNT FEE INC.	96,000	9	374		4,320	17	5
6	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,931		4,320	312	6
7										7
8										8
9	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	81,858	81,858	2	4,026	9
10	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,762		2	234	10
11	17	ADMIN. SALARY	DIRECT ALLOCATION							11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 95,664	$ 81,858		$ 4,667	25

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PARAMOUNT HEALTH CARE SYSTEMS
Street Address: 6300 OAKTON
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847)470-4700
Fax Number: (847)470-4718

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	ENTERAL EQUIPMENT	DIRECT ALLOCATION						123	1
2	10	ENTERAL EQUIPMENT	DIRECT ALLOCATION						87	2
3	1	NUTRITIONAL SUPPLEMENTS	DIRECT ALLOCATION						1,155	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,365	25

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Comercial Nat'l Bank		X	Mortgage	$21,789.13		$ 2,375,000	$ 2,107,570	10/1/2000		$ 201,639	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIB Bank/S.I.R. Line		X	WORKING CAPITAL				290,000		PRIME	15,037	6
7												7
8												8
9	TOTAL Facility Related				$21,789.13		$ 2,375,000	$ 2,397,570			$ 216,676	9
	B. Non-Facility Related*											
10	Supplemental Schedule										2,174	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 2,174	14
15	TOTALS (line 9+line14)						$ 2,375,000	$ 2,397,570			$ 218,850	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Allocation-Preferred Bookkpng	X					$	$			$ 701	1
2	Allocation-SIR Management	X									1,456	2
3	Allocation-Extended Care Mgmt	X									17	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 2,174	21

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	44,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	47,699	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,299	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	47,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	50,399	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	37,231	8
	1996	39,877	9
	1997	42,082	10
	1998	43,085	11
	1999	45,397	12

ACCRUAL=45,397*1.04=$47,100

2000 TAXES PAID INCLUDES ALLOCATION FROM PREFERRED BOOKKEEPING OF $908 AND ALLOCATIONFROM SIR MANAGEMENT OF $1394

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,802 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY			$ 95,000	1
2					2
3	TOTALS			$ 95,000	3

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	95		1995		$ 1,915,000	$ 49,103	35	$ 54,714	$ 5,611	$ 305,447	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1988	63,854	1,264	20	3,194	1,930	19,164	9
10	VARIOUS			1991	4,502	90	20	224	134	1,815	10
11	VARIOUS			1992	11,983	380	20	599	219	4,992	11
12	VARIOUS			1993	27,711	298	20	1,384	1,086	11,797	12
13	VARIOUS			1994	30,063	396	20	1,503	1,107	10,578	13
14	VARIOUS			1995	27,496	1,583	20	1,375	(208)	7,300	14
15	WALLPAPER			1996	20,725	531	20	1,036	505	4,317	15
16	KITCHEN PLUMBING			1996	6,400	164	20	320	156	1,573	16
17	UPGRADE FIREL ALARM			1996	33,624	862	20	1,681	819	7,985	17
18	PIPE LINE			1996	6,800	174	20	340	166	1,502	18
19	FLOORING			1996	5,068	573	20	253	(320)	1,117	19
20	WATERPROOF BLDG			1996	2,050	53	20	103	50	429	20
21	PAINT RESIDENT ROOMS			1996	9,000	231	20	450	219	1,875	21
22	AIR CONDITIONING			1996	17,800	456	20	890	434	4,376	22
23	SHOWER CABINET/WHIRL			1996	22,051	565	20	1,103	538	4,504	23
24											24
25	PAGE 12-1 REP TOTALS				43,560	1,795		1,705	(90)	9,411	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				75,229	2,312		1,874	(436)	1,876	34
35	PAGE 12A TOTALS				184,663	13,641		9,500	(4,141)	20,461	35
36	TOTAL (lines 4 thru 35)				$ 2,507,579	$ 74,471		$ 82,248	$ 7,779	$ 420,519	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	INSTALL WALLCOVERING			1997	6,797	174	20	340	166	1,247	9
10	BATHROOM REMODELING			1997	6,250	160	20	313	153	1,148	10
11	PHONE SYSTEM			1997	3,414		20	171	171	669	11
12	WINDOW/ROOM DIVIDERS			1997	14,573	1,679	20	729	(950)	2,855	12
13	ROOM DIVIDERS			1997	730	84	20	37	(47)	142	13
14	CARPETING			1997	2,621	302	20	131	(171)	502	14
15	INSTALL TUB			1997	1,116	29	20	56	27	224	15
16	CARPETING			1997	7,349	846	20	367	(479)	1,315	16
17	BOILER			1997	2,075	239	20	104	(135)	572	17
18	REPLACE MIXING VALVE			1997	5,335	137	20	267	130	1,058	18
19	SEWER WORK			1998	7,200	185	20	360	175	930	19
20	DOOR MONITOR SYSTEM			1998	1,816	370	20	91	(279)	220	20
21	HEAT EXCHANGER			1996	5,254	575	20	525	(50)	2,144	21
22	BOILER			1998	1,550		20	78	78	176	22
23	PA SYSTEM			1998	1,463		20	73	73	207	23
24	BOILER			1998	1,155		20	58	58	164	24
25	PAINTING & DECORATING			1999	7,644		20	382	382	382	25
26	NEW ELEVATOR			1999	44,790	1,148	20	2,240	1,092	2,613	26
27	WATER HEATER			1999	1,585	412	20	79	(333)	158	27
28	NEW WIRING			1999	34,200	877	20	1,710	833	1,995	28
29	WINDOWS			1999	13,712	5,210	20	686	(4,524)	858	29
30	A/C COMPRESSOR			1999	1,256		20	63	63	63	30
31	FIRE DOORS			1999	1,267		20	63	63	63	31
32	EXHAUST FAN			1999	2,500		20	125	125	125	32
33	WEST WING PUMP			1999	1,671		20	84	84	84	33
34	BOILER			1999	3,770		20	189	189	189	34
35	COMPRESSOR			1999	3,570	1,214	20	179	(1,035)	358	35
36	TOTAL (lines 4 thru 35)				$ 184,663	$ 13,641		$ 9,500	$ (4,141)	$ 20,461	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HEAT EXCHANGER			2000	4,014	803	20	201	(602)	201	9
10	ELEVATOR WORK			2000	4,433	887	20	222	(665)	222	10
11	ELEVATOR WORK			2000	1,450	290	20	61	(229)	61	11
12	BOILER			2000	44,860	240	20	561	321	561	12
13	ELECT WORK			2000	7,800	92	20	195	103	195	13
14	ELECTRIC ELEVATORS			2000	1,025		20	51	51	51	14
15	PLUMBING SEWER			2000	850		20	43	43	43	15
16	FIRE SMOKE DAMPER			2000	860		20	43	43	43	16
17	PLUMBING SEWER			2000	1,600		20	80	80	80	17
18	ELECTRIC - A/C			2000	1,191		20	60	60	60	18
19	BOILER PIPING			2000	721		20	36	36	36	19
20	HANDRAILS			2000	1,232		20	62	62	62	20
21	AIR CONVECTOR VENTS			2000	1,179		20	59	60	60	21
22	HEAT EXCHANGER			2000	4,014		20	201	201	201	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 75,229	$ 2,312		$ 1,874	$ (436)	$ 1,876	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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14											14
15											15
16											16
17											17
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993	SIR-PRP-PB	$ 8,378	$ 266	35	$ 239	$ (27)	$ 1,795	4
5			1993	SIR PRP-MGT	12,871	409	35	368	(41)	2,758	5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATION-PREFERRED BOOKKEEPING			1997	10,462	394	20	523	129	1,993	9
10	ALLOCATION-PREFERRED BOOKKEEPING			1999	83	27	20	4	(23)	6	10
11	ALLOCATION-PREFERRED BOOKKEEPING			2000	525		20	11	11	11	11
12	ALLOCATION-SIR PROPERTIES-PREF BOOKPNG			1999	1,062	106	20	53	(53)	80	12
13	ALLOCATION-SIR PROPERTIES-PREF BOOKPNG			1998	507	51	20	25	(26)	63	13
14	ALLOCATION-SIR PROPERTIES-PREF BOOKPNG			1997	32	3	20	2	(1)	7	14
15	ALLOCATION-SIR PROPERTIES-PREF BOOKPNG			1994	80	2	20	4	2	26	15
16	ALLOCATION-SIR PROPERTIES-PREF BOOKPNG			1993	136	7	20	7		51	16
17	ALLOCATION-SIR MANAGEMENT			1993	5,528	184	20	279	95	2,179	17
18	ALLOCATION-SIR MANAGEMENT			1994	17		20	2	2	11	18
19	ALLOCATION-SIR MANAGEMENT			1995	126	7	20	6	(1)	34	19
20	ALLOCATION-SIR MANAGEMENT			1999	600	40	20	30	(10)	36	20
21	ALLOCATION-SIR MANAGEMENT			2000	363	39	20	13	(26)	13	21
22	ALLOCATION-SIR PROPERTIES-SIR MGMT			1999	1,631	163	20	82	(81)	122	22
23	ALLOCATION-SIR PROPERTIES-SIR MGMT			1998	779	78	20	39	(39)	97	23
24	ALLOCATION-SIR PROPERTIES-SIR MGMT			1997	48	5	20	2	(3)	11	24
25	ALLOCATION-SIR PROPERTIES-SIR MGMT			1994	123	3	20	6	3	40	25
26	ALLOCATION-SIR PROPERTIES-SIR MGMT			1993	209	11	20	10	(1)	78	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 43,560	$ 1,795		$ 1,705	$ (90)	$ 9,411	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 480,172	$ 41,869	$ 47,380	$ 5,511		$ 255,858	37
38	Current Year Purchases	6,800	1,347	429	(918)		429	38
39	Fully Depreciated Assets	85,690	766	308	(458)		85,690	39
40								40
41	TOTALS	$ 572,662	$ 43,982	$ 48,117	$ 4,135		$ 341,977	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,175,241	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 118,453	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 130,365	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 11,914	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 762,496	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

HIGHLAND PARK HEALTH CARE, INC.
0032854
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
Highland Park Health Care Center Assoc LLC	190,000	17,722	19,000	1,278	101,333
Highland Park Health Care Center	259,767	21,857	25,427	3,570	135,394
Preferred Bookkeeping	12,154	870	1,128	258	7,454
SIR Properties-Preferred Bookkeeping	8		1	1	6
SIR Management	18,231	1,420	1,823	403	11,662
SIR Properties-SIR Management	12		1	1	9
TOTALS	480,172	41,869	47,380	5,511	255,858

LINE 29: CURRENT YEAR

Highland Park Health Care Center Assoc LLC					
Highland Park Health Care Center	5,874	1,176	371	(805)	371
Preferred Bookkeeping	354	71	30	(41)	30
SIR Properties-Preferred Bookkeeping					
SIR Management	572	100	28	(72)	28
SIR Properties-SIR Management					
TOTALS	6,800	1,347	429	(918)	429

LINE 30: FULLY DEPRECIATED

Highland Park Health Care Center Assoc LLC					
Highland Park Health Care Center	85,690	766	308	(458)	85,690
Preferred Bookkeeping					
SIR Properties-Preferred Bookkeeping					
SIR Management					
SIR Properties-SIR Management					
TOTALS	85,690	766	308	(458)	85,690

TOTALS (Should Tie to Totals on Page 13)

Highland Park Health Care Center Assoc LLC	190,000	17,722	19,000	1,278	101,333
Highland Park Health Care Center	351,331	23,799	26,106	2,307	221,455
Preferred Bookkeeping	12,508	941	1,158	217	7,484
SIR Properties-Preferred Bookkeeping	8		1	1	6
SIR Management	18,803	1,520	1,851	331	11,690
SIR Properties-SIR Management	12		1	1	9
TOTALS	572,662	43,982	48,117	4,135	341,977

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 4,814 Description: SEE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	95 DODGE UTILITY	$ 300.08	$ 3,311	17
18	ALLOC - PREF BKKG			1,187	18
19	ALLOC - SIR MGT			2,863	19
20	ALLOC - ECM			312	20
21	TOTAL		$ 300.08	$ 7,673	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 7,502	$		$ 7,502	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,906			1,906	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			9,186			9,186	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				4,922		4,922	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2					3,506		3,506	13
14	TOTAL			$		$ 18,594	$ 8,428		$ 27,022	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	2,516
2	Complex Medical Equip	336
3	X-Ray	530
4	Equipment Rental	
5	Lab Expense	124
6		
7		
8		
9		
10		
		3,506

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 81,392	$ 81,584	1
2	Cash-Patient Deposits	24,892	24,892	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	312,320	312,320	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,022	4,022	6
7	Other Prepaid Expenses	252	252	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	13,031	13,031	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 435,909	$ 436,101	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		95,000	13
14	Buildings, at Historical Cost		1,915,000	14
15	Leasehold Improvements, at Historical Cos	365,165	365,165	15
16	Equipment, at Historical Cost	481,222	671,222	16
17	Accumulated Depreciation (book methods)	(470,952)	(916,697)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 375,435	$ 2,129,690	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 811,344	$ 2,565,791	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 70,092	$ 70,092	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,239	27,239	28
29	Short-Term Notes Payable	290,000	290,000	29
30	Accrued Salaries Payable	102,019	102,019	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,249	6,249	31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,100	47,100	32
33	Accrued Interest Payable	804	18,966	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	2,800	2,800	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 546,303	$ 564,465	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,107,570	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,107,570	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 546,303	$ 2,672,035	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 265,041	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 811,344	$ #REF!	48

*(See instructions.)

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. **#** 0032854 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	13,031	13,031
	13,031	13,031

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Replacement Tax	1,500	1,500
Deferred Replacement Tax	1,300	1,300
	2,800	2,800

OTHER NON CURRENT ASSETS:

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 480,406	1	
2	Restatements (describe):		2	
3	Schedule attached		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 480,406	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	4,135	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(219,500)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (215,365)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 265,041	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	HIGHLAND PARK HEALTH CARE, II #	0032854	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		480,406
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		480,406
Equity(Deficit) from Page 17 Col 1		265,041
Related Party		
Equity(Deficit)	-357533	
Income	-13752	
		(371,285)
Combined Equity - End of Year		(106,244)

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,903,217	1
2	Discounts and Allowances for all Levels	(44,530)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,858,687	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	44,910	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 44,910	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	8,489	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	337	19
20	Radiology and X-Ray		20
21	Other Medical Services	23,623	21
22	Laundry	1,135	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 33,584	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,937,181	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	604,348	31
32	Health Care	1,203,073	32
33	General Administration	668,825	33
	B. Capital Expense		
34	Ownership	376,864	34
	C. Ancillary Expense		
35	Special Cost Centers	27,780	35
36	Provider Participation Fee	52,156	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,933,046	40
41	**Income before Income Taxes (line 30 minus line 40)****	4,135	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 4,135	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HIGHLAND PARK HEALTH CARI # 0032854 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,938	2,105	$ 91,887	$ 43.65	1
2	Assistant Director of Nursing	1,016	1,181	26,279	22.25	2
3	Registered Nurses	7,250	7,843	164,932	21.03	3
4	Licensed Practical Nurses	4,680	5,084	91,711	18.04	4
5	Nurse Aides & Orderlies	43,780	45,149	471,819	10.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	909	995	11,432	11.49	9
10	Activity Assistants	3,540	4,061	34,310	8.45	10
11	Social Service Workers	1,778	2,091	23,901	11.43	11
12	Dietician					12
13	Food Service Supervisor	1,709	2,091	34,781	16.63	13
14	Head Cook	4,858	5,389	44,425	8.24	14
15	Cook Helpers/Assistants	11,187	11,636	67,348	5.79	15
16	Dishwashers					16
17	Maintenance Workers	1,827	1,976	25,618	12.96	17
18	Housekeepers	10,788	11,670	76,567	6.56	18
19	Laundry	4,184	4,462	27,695	6.21	19
20	Administrator	1,930	2,091	61,509	29.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,684	5,869	61,427	10.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,857	3,232	43,611	13.49	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	109,915	116,925	$ 1,359,252 *	$ 11.62	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	152	$ 7,800	1-3	35
36	Medical Director	Monthly	2,400	9-3	36
37	Medical Records Consultant	Monthly	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	86	2,568	10-3	39
40	Physical Therapy Consultant	66	3,567	10A-3	40
41	Occupational Therapy Consultant	60	3,216	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	66	447	10A-3	43
44	Activity Consultant	60	3,124	11-3	44
45	Social Service Consultant	29	1,374	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	519	$ 28,528		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,312	$ 84,227	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides	5,197	92,012	10-3	52
53	TOTAL (lines 50 - 52)	7,509	$ 176,239		53

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
THOMAS PARISI	ADMINISTRATOR	0	$ 61,509
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,509

B. Administrative - Other

Description	Amount
MANAGEMENT FEES - SEE ATTACHED	$ 127,171
TOTAL (agree to Schedule V, line 17, col. 3)	$ 127,171
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PREFERRED BOOKKEEPING	ACCOUNTING	$ 20,200
FROST, RUTTENBERG	ACCOUNTING	19,865
PREFERRED BOOKKEEPING	BOOKKEEPING	31,920
PREFERRED BOOKKEEPING	COMPUTER SVCS	2,280
MID AMERICA PROGRAMMING	COMPUTER SVCS	1,320
ICS SOLUTIONS	COMPUTER SVCS	75
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	636
SCHWARTZ & FREEMAN	LEGAL FEES	12,163
STONE, MCGUIRE & BENJAMIN	LEGAL FEES	2,518
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 90,977

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 15,496
Unemployment Compensation Insurance	8,000
FICA Taxes	103,761
Employee Health Insurance	29,039
Employee Meals	19,435
Illinois Municipal Retirement Fund (IMRF)*	
UNION HEALTH & WELFARE	26,068
EMPLOYEE BENEFITS	6,029
TOTAL (agree to Schedule V, line 22, col.8)	$ 207,828

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,586
Health Care Worker Background Check	
(Indicate # of checks performed 27)	326
DUES AND SUBSCRIPTIONS	2,706
LICENSES & FEES	781
YELLOW PAGE ADVERTISING	10,736
ALLOCATION-PREFERRED BOOKPNG	217
ALLOCATION-SIR MGMT	494
ALLOCATION ECM	12
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(10,736)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,122

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,362
ALLOCATION PREFERRED BOOKPNG	110
ALLOCATION-SIR MGMT	268
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,740

**See instructions.

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HIGHLAND PARK HEALTH CARE, INC. # 0032854 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON L/T CARE $2,695**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,800** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **52,155**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **19,435** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw